Chapter 7

# Queer in practice

## Therapy and queer theory

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As clinical psychologists in HIV and sexual health services, we have chosen to use queer theory to influence our work because it is located within a postmodern epistemology, which deconstructs and challenges normative and heteronormative discourses, including those relating to relationships and sex. A queer theory approach allows us to join with our clients in constructing new meanings and narratives outside the limiting and oppressive societal and cultural definitions of what is 'normal', 'healthy' and 'desirable'. Thus this approach provides a challenge to traditional psychological therapies which can be based on Western, heteronormative ideals. This is essential for work with our clients who often come from ethnic and sexual minority groups. In this chapter we discuss the theoretical underpinnings of our work, providing clear examples and transcript to illustrate our approach. This involves systemic and social constructionist models, as well as a queer critique of heteronormative models of sex, sexuality and relationship. We will challenge traditional notions of 'client' and 'expert' and present an alternative approach to therapeutic ethics. We will also describe some of the techniques we use to introduce a queer perspective in training psychologists.

### Background

Queer theorists challenge basic assumptions about sex, gender and sexuality, including the dichotomies of heterosexual/homosexual and male/female and thus develop new ways of exploring issues of human identity and relationships (Spargo 1999) – issues that are arguably of prime importance and interest to psychologists. Yet, while queer theory has been highly influential within the fields of cultural and literary studies and philosophy, it has had less impact on the theory and practice of psychology.

'Queer' is not a term that is generally used or recognised within mainstream psychology, except perhaps to a limited extent within its academic sphere. Within training it is practically non-existent, with case studies,

research subjects and issues being almost exclusively heterosexual, or the sexuality of subjects not being mentioned at all, as it is assumed they are heterosexual and that this does not need stating. Even when 'difference and diversity' modules are included in the curriculum, sexuality can exclude even more recognised categories like 'lesbian' and 'gay' (Butler 2004a), or at best given a slot for three hours on a three-year training programme. One reason for this is that the notion of 'queer' – either in its popular usage as an alternative identity or as a set of practices that unsettle assumptions about sexual identity and behaviour – cannot be easily accommodated in most psychological models. This is for a number of reasons.

First, where sexuality is addressed within psychology and psychotherapy, it is conceptualised as an individual and 'internal' attribute, i.e. individual people are described as 'heterosexual' or 'homosexual', 'gay' or 'straight'. The same is true of mainstream psychological views of gender and gender identity. In contrast, 'queer' is a socio-cultural and political concept. For example, queer theorists such as Judith Butler present gender as a 'performative effect' that is experienced by the individual as natural identity (Butler 1990). For Butler, gender is not the conceptual or cultural extension of chromosomal or biological sex but rather an ongoing discursive practice that is currently structured around the concept of heterosexuality as the norm of human relationships (Spargo 1999). The psychological view of gender and sexual identity as individual and internal has been criticised (e.g. Kitzinger 1989) as obscuring the political and allowing psychologists to ignore the mechanisms of power and oppression in the lives of their clients.

Second, as already mentioned, mainstream psychological models tend to accept the binary categories of 'male/female' and 'homosexual/heterosexual'. Traditionally, heterosexuality has been accepted as 'normal' and 'natural', while homosexuality has generally been treated as a 'problem' to be explained (nature versus nurture) or a pathology to be cured. The history of the pathologisation of lesbians, gay men and bisexuals by psychology has been extensively discussed elsewhere (e.g. Kitzinger 1990) and will not be covered in detail here. While these approaches have changed and, in the UK at least, psychologists no longer offer therapy aimed at changing someone's sexual preference, there still tends to be an acceptance of binary categories and of the idea of sexual identity as internal, individual and fixed. For example, when we turn to look at psychological approaches to transgendered identities, we can see that they are conceptualised almost totally within a medical/pathology model, i.e. the concept of 'gender dysphoria' or 'gender identity disorder' as a medical or psychiatric diagnosis (Denman 2004). In queer theory terms, psychology may thus be described as being involved in the production of knowledges that have served to reinforce the normalising of heterosexuality and gender dichotomy and the oppression of other practices and identities.

Psychology as a profession has traditionally positioned itself within a 'scientist-practitioner' model, emphasising that therapeutic practice should be based on 'scientific' psychological research. This view is associated with a positivist epistemology and the idea of the psychologist as objective observer. In line with this, the development of cognitive behavioural therapy (CBT) since the 1970s offered an alternative to psychodynamic ways of working, but one that still conceptualises problems as individual and internal, for example arising from faulty thinking patterns. CBT fits into the current climate of evidence-based practice, often viewed as the 'gold standard' within the National Health Service (NHS), our working context as clinical psychologists in the UK. Given the contexts outlined above, it is reasonable to question whether, as clinical psychologists, it is possible to be queer in practice, and if it is possible, what can that look like? In the following sections, we will outline the theoretical underpinnings of our approach to therapy and elucidate why we think this is compatible with queer theory and practices and appropriate to working with clients who have been or may be ab-normalised by mainstream psychological therapy.

## An alternative approach

As therapists who have worked primarily within the NHS and also in the voluntary sector, we have met with hundreds of individuals and couples with relationship and sexual difficulties. In our work together, we have found useful alternative approaches to that provided by more traditional psychological theory. We base our work on social constructionist principles, as developed and operationalised with post-Milan systemic therapy and narrative therapy. Systemic therapy was developed in theory and practice by a team of four psychotherapists – Cecchin, Bocoloio, Prata and Selvini-Palazzoli – based in Milan during the 1970s and 80s. Their ideas were mainly inspired by the work of communication theorist Gregory Bateson, who emphasised the importance of attending to 'the difference that makes the difference' (Bateson 1972) in that change occurs when people experience its possibility. In the 1980s, the rise of postmodernist thinking, particularly social constructionism and feminist theory, shaped systemic therapy further as it entered the 'post-Milan' era. Systemic therapy of the 1990s and beyond takes account of power and social differences in ways that we feel complement queer theory and our work with lesbian, gay, bisexual and trans clients. It allows for a different perspective on therapist–client relationships and practices, with particular emphasis on power relations, knowledge and language (Simon and Whitfield 2000). This model also acknowledges and accommodates the importance of self-reflectivity, which we feel is essential for practitioners both in clinical work and research. Our own self-reflections on how we are positioned in our work and the key connections between these two approaches are now discussed.

### *A postmodern approach*

Postmodernism has provided a critique of the notions of universal truths, scientific method and objectivity (Simon and Whitfield 2000). Within this critique, an individual's 'realities' are socially constructed and constituted through language and discourse and there are no essential truths. This approach stands in contrast to a positivist epistemology and instead invites a reflexive way of knowing that recognises how therapists are inevitably acting out of their own beliefs, cultural context and experience. These will influence the conversation we have with clients and the meaning we jointly construct around the topic discussed. Wittgenstein (1952) refers to this as the creation of local knowledges, to recognise that meaning arises through language use within local contexts and not by finite, universal definitions of words. Therefore, we do not consider ourselves to be objective observers but part of the 'system' that is operating in the client's life.

Queer theory itself is under the umbrella of postmodernism, where universal truths or structures give way to a 'multiverse' or plurality of ideas about the world (Lax 1992), and so different realities are recognised as being equally valid. For example, it is considered that there are multiple ways to 'perform gender' or to conduct relationships. This approach is critical to our work as it allows us to take a non-heteronormative stance. And so we may work with people who choose a variety of relationship structures, e.g. non-monogamy, or those who do not engage in penetrative sex (vaginally or anally). We would see our task in therapy as clarifying the sexual and relational choices that each member makes so that the relationship of choice is negotiated and understood by all involved. The following example shows why and how two men brought their issues to Angela.

Jonathan, a 35-year-old white British man, and Kai, a 40-year-old Thai man, attended for therapy due to increasing conflict in their relationship. They reported that for the first two years of their relationship they were very happy and experienced little conflict. During this time they described themselves as 'fuck buddies'. Several months ago, they decided to become 'boyfriends'. It was soon after this that they began to have arguments. Kai reported that Jonathan was constantly calling and texting him throughout the day, and he felt that he was being checked up on. Jonathan reported that he felt extremely anxious when they were apart. He was worried that Kai was going to saunas to have sex and felt Kai withdrawing from him, resulting in feelings of panic. Below is an example of a conversation aimed at exploring and clarifying their relational choices.

AB: How was it decided that you would become 'boyfriends'?

Jonathan: Well, I guess it was my idea but I think we both agreed on it.

(Kai nods)

AB: How did you see things changing when you became 'boyfriends'?

Jonathan: Well, I think it means that you do things together and that it's not just about sex anymore.

AB: How about you, Kai? What does being 'boyfriends' mean to you?

Kai: It does mean doing things together but still having your own life. I think sex is still really important and now it feels like certain things are off limits. . . .

Jonathan: What do you mean?

Kai: Like, we used to go to the sauna together, but that doesn't happen any more.

Jonathan: But that's not really what boyfriends do, is it?

AB: It sounds like you might have some different ideas about what being boyfriends means. I was wondering where do your ideas come from about what it means to be boyfriends?

Jonathan: I don't know really. I suppose I think about my sister and her husband. They're very close and do everything together . . . and my parents are still together and . . . I suppose it's just something you aspire to.

Kai: But they're straight. It's not really the same is it? Most of the long-term gay couples I know don't have sex with each other anymore, and that's not what we want. I had that with my partner, Richard, but I think 'boyfriends' is different. It means we still have sex.

Jonathan: I kind of think of 'partners' and 'boyfriends' as the same.

AB: How was it when you were 'fuck buddies'?

Jonathan: We knew where we stood then.

Kai: Yes. The rules were pretty clear so we never had problems.

AB: What do you think helped you to be clear?

Kai: Well, we've both been on the scene for a while. Everybody knows what 'fuck buddies' means. It's like you agree to meet when its mutually convenient and you don't have any other expectations of it.

Jonathan: But also we talked about it and agreed. I guess we never really talked about what being boyfriends would mean before.

AB: If we were to imagine a definition of 'boyfriends' that would be relevant to you as gay men, what might that look like?

### A 'non-expert' stance

Traditionally, psychologists have taken an 'expert' position in therapy, e.g. helping clients to adjust their 'negative automatic thoughts' or interpreting 'transference' in the therapy room. In contrast, systemic and social constructionist therapists take a 'non-expert' or 'not-knowing' stance (Anderson and Goolishian 1992). In other words, while we have knowledge of, or 'expertise' in, the process of therapy, the client is the expert on their own meaning and experience, not the therapist. By positioning ourselves as non-expert, we thus acknowledge and respect the choices and power of the client. Our mindfulness in how this stance positions ourselves and the client fits with Foucault's (1978) ideas that power is relational and not the possession of an individual. We therefore cannot 'empower' clients, which would imply we have power to give them, but position ourselves in a way that draws on the power they use to make life choices. Foucault suggested that we can never be free of power but can resist it when it is oppressive. Queer theorists (e.g. Sedgwick 1990; Halperin 1995) applied these ideas to heterosexism, while feminist theorists (e.g. Haraway 1991) have used them to challenge patriarchy (Minton 1997). An example of how this resistance can be used therapeutically, is to ask 'what is the problem and for whom?'. This acknowledges that it is the dominant majority who often define a problem, e.g. non-monogamy being described as 'promiscuity' when compared to heteronormative ideas of marriage and commitment.

What is queer is therefore that which is subjugated in relation to that which is dominant, not the affirmation of an alternative identity: it is to be 'other'. This idea becomes very interesting when applied to the context in which we work, HIV/sexual health services, as staff and clients often hold multiple and overlapping roles: as service users, service providers, volunteers and campaigners. In addition, contributing to and because of the culture of sexual health services, many lesbians, gay men and bisexuals choose to work in this area. This can result in an overlap between a therapist's personal and professional life (for a detailed examination of this issue, see Taylor, Slots, Roberts and Maddicks, 1998, who describe their work as gay therapists who see gay clients and share the 'scene' in Brighton). Similarly, the advent of the Gaydar web site and similar sites creates additional possibilities for clients and therapists to be exposed to each others' sexuality, which will need to be addressed in the context of therapeutic boundaries and ethics. The recognition and acceptance of these dual roles

contributes to the therapist not 'othering' the client through subjugation by taking an expert role.

Clients may also live their relationships in ways that do not mirror our own relationship choices, and we would try to celebrate rather than pathologise this difference. Our curiosity and respect about the choices clients make move us away from 'norm-based' ideas of sex and relationships. We can ask questions that validate and support client decisions, as well as assisting clarity and revision, such as 'As a couple, how did you negotiate the rules of your non-monogamy?'. By recognising the fluidity of people's lives, identities and practices, we can help them affirm the choices they have made for their life at this time, and not impose cultural or heteronormative ideas of how relationships should develop. The following example involves a heterosexual couple who worked for over a year with Catherine.

Fatima and Abdul were referred for therapy with CB because they had not had penetrative sex for three years. Fatima had been raped by a gang of soldiers in their country of origin, and the couple had come to England to seek asylum. They were both strict Muslims and when asked why penetrative sex was important, Fatima explained that it was her duty as a wife and they hoped to have children in the future. Sex was therefore not seen as something that was for pleasure, which conflicted with CB's feminist views. The couple also told CB that the idea of 'foreplay' would not be acceptable to them, because it was for pleasure, which made following a step-wise typical sex therapy programme difficult. CB took a transparent perspective and spoke about the differences in their views given their cultural and religious differences. This allowed CB to investigate other ideas within the Muslim faith around sex, and she discovered two important pieces of information – that foreplay is permitted within a marriage if performed as a couple and not as masturbation, and that if there is a medical reason, decrees from the Koran can be set aside (e.g. a diabetic can eat in Ramadan). By taking a non-expert stance and presenting this information as ideas that CB had come across, an opportunity was created for the couple to discuss exercises in touching that would be acceptable to them, if not placed under the title of foreplay. The couple began a programme of mutual massage and Fatima began to explore her genitals. CB also explained to the couple that Fatima could still get pregnant without penetrative sex if they used a syringe to insert the sperm. The couple rejected this idea at first. However, as Fatima became able to insert her finger into her vagina, they spoke again about using syringes to get pregnant, not telling CB they had

this discussion. CB was therefore extremely surprised when Fatima started a session by announcing that she was six weeks pregnant, while they still had not had penetrative sex! One of the meanings behind why penetrative sex was important had therefore been achieved, and Fatima was also fulfilling her duty as a wife by providing Abdul with a child. The couple therefore used CB's ideas as suggestions to draw out their own resourcefulness and ability to communicate and create solutions to find a way to be intimate and have children, without penetrative sex.

### *Multiple perspectives*

In line with queer resistance of the dominant norm, Maturana (1978) has influenced systemic therapy with his ideas of multiple perspectives. He suggests that reality is a 'multiverse', rather than a 'universe', as there is not one true reality but multiple possibilities. Thus, we acknowledge that as therapists our ideas about the world and lived experience may be different in more or less ways to the ideas and lived experiences of our clients. This perspective provides a means of resisting subjugated discourses that clients may present with. This is illustrated below with the example of a client who met with Catherine saying she was 'confused' about her sexuality.

Athena presented for therapy with CB because she was 'confused about her sexuality'. She had been a strict Christian all her life and had recently had penetrative vaginal sex with a man for the first time (she was in her 40s). However, the man she had started a sexual relationship with was married, which troubled her. Her confusion was around the fact that she was enjoying a new-found sense of her sexuality but felt guilty about the circumstances as it conflicted with her morality as learnt within her church. She had spoken to her church leader about this and was advised to stop attending her church until the relationship had ended. The multiple perspectives on her current situation were in conflict. In therapy, I was also influenced in hearing her story (as you are in reading it) by my own multiple perspectives, which for me included being agnostic and sexually active. By acknowledging there were different views about her situation, both within the room and within different parts of her community, we could examine which ideas she found more or less helpful and so which she might hold onto or reject. An example of this conversation follows.

Athena: I don't want to give this up, he makes me feel alive in a way I have never felt before. But, at the same time, he is married, so I am breaking one of the Ten Commandments.

CB: Who else might share this view?

Athena: Well the church. This is what is so painful. To be with him I have to forfeit the community that has given me support and love all of my life. But the thought of being without him is also so painful.

CB: And is there anyone who might have a different view to this?

Athena: Well, I told my brother. He is not religious and he was happy for me. But I don't think he understands.

CB: You know I am not religious. Do you feel that I can understand the dilemma you find yourself in?

Athena: I think it helps that you are not in the church because I do not feel that you are judging me. You might think I'm being silly though because I am obviously older than you?

CB: I don't think you are silly but it seems as if you are struggling to bring together these two parts of your identity that are important to you: your relationship with God and your relationship with this man. Do you still feel you have a relationship with God, even if your relationship with the church has been damaged?

Athena: I hadn't thought of that before. Yes, I still pray everyday and ask his forgiveness and guidance on what I should do.

CB: I'm not sure how these things work (laughter) but have you had some answers or suggestions?

Athena: (laughter) Well I guess I still feel close to God, despite this. I still feel his love, and he is a forgiving God.

CB: So is it possible to keep your relationship with God, while you explore this sexual part of yourself?

Athena: It is not ideal, but my situation feels different to what I had expected from my life anyway. I always thought I would be married with children at this age.

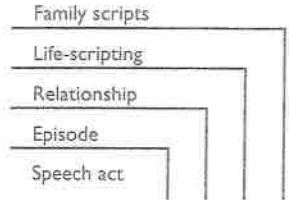
CB: So maybe there are ways of doing things differently to what is expected. What other examples of this can you think of?

### *Levels of context*

Different perspectives are also considered if we examine how different contexts influence meaning-making. Cronen and Pearce (1980, 1985) developed a framework for considering which contexts influence meaning-making and how these contexts relate to each other. Their model, the

coordinated management of meaning (CMM), considers that contexts determine social meanings and actions developed from Bateson's (1972) statement that 'without context there is no meaning'. This model was originally developed in a hierarchical format (Cronen and Pearce 1985):

*The hierarchical model of coordinated management of meaning*




Speech acts occur within episodes of interaction that are defined and organised by the relationship between speakers that is shaped by stories of possibility from the family of origin. In later uses of the model, the contextual layer of 'culture' was added to specify that all the above occurs in a specific cultural context (e.g. Pearce 1994). These layers of meaning will be influencing each member of a conversation as it progresses. We therefore consider both the contextual influences on our meaning-making, as well as asking questions to consider how these will be influencing the meaning-making of the client. For example:

> "How is your interest in sadomasochistic practices received within your relationships?
> Within the ideas of your family of origin?
> Within lesbian culture?
> Within British culture?"
> "Which of these messages do you find most supportive / helpful?"
> "What alternatives to the judgemental messages might be possible within that same culture / family / relationship?"

This thus fits with queer ideas of resisting 'norm-based' dominant cultural messages. This approach is demonstrated below in individual therapy with Angela.

Jose, a 32-year-old Spanish gay man, was referred for therapy for depression by his HIV physician. In the referral, the doctor noted that Jose 'takes part in self-destructive sexual practices' and speculated that this was the source of his Hepatitis C infection. Jose mentioned that he was referred for therapy previously by his GP but that he

didn't find it helpful. He said the therapist didn't really understand him. After a number of sessions, he began to discuss his sexual relationship and said that he felt he had a 'problem with sex'. The therapist (AB) asked when he started thinking that he had a 'problem with sex'. Jose said that he had enjoyed SM sex for a number of years and met his current partner, Peter, at an SM club. They regularly brought other men home to 'play', and Jose often felt inadequate in these scenarios. He felt criticised by Peter for not being adventurous enough and often felt low afterwards. When he discussed this with his previous therapist, she speculated that his interest in SM practices was a form of 'internalised homophobia', or an expression of guilt for his homosexuality and something that prevented him and Peter having a healthy, intimate relationship. AB wondered aloud who the SM was a problem for and who was most and least concerned about it? Through this process of deconstructive questioning, Jose identified that the 'problem' for him was not the SM practices (which he had always enjoyed) but the extent to which he felt criticised by Peter. It emerged that this criticism was apparent in other situations too and the focus of the work became how Jose could assert his needs and resist criticism, both in his sexual relationships and in other areas of his life.

### *The use of teams*

Another example of the valuing of multiple perspectives is the use of teams in narrative and systemic therapies, generally referred to as 'reflecting teams' (e.g. Andersen 1987). Teams have commonly been used throughout the history of family therapy, where a team of therapists traditionally observe the therapist and clients from behind a one-way mirror, invisible to the clients, and deliver messages or interventions to the therapist from their 'expert' position. In contrast, teams are used by post-Milan systemic and narrative models of therapy with the aim of increasing transparency and bringing multiple perspectives to the client's circumstance. In these approaches, the team is often in the room with the client and therapist, who are invited to listen to the team's reflections after which the client is invited to comment on what they heard. The client listens to these views from their position as expert on themselves, and so they are invited to reject, expand or just comment on the observations of team members. Team members may locate the position they speak from, for example, 'as a single gay man, I was struck by Tony's thoughtfulness in his preparations for sexual encounters' or 'as a bisexual woman, I was left wondering how Annie's expectations of her partner might be different if her partner was male'.

Some narrative therapists have expanded this idea to involve teams whose members may share the issue of concern with the client e.g. women who have recovered from anorexia (Madigan and Epston 1995). This practice has been termed using 'outsider witnessing' groups. The purpose of such groups is to recruit an appropriate and supportive audience for the development of the clients' preferred futures. Such practices fit within the queer agenda of resisting, undermining and providing alternative views to dominant, heteronormative practices in therapy.

### *Deconstructionist practices*

Like queer theories, social constructionist and systemic therapists are influenced by the work of Foucault in his examination of the various ways that people in Western societies have been categorised as 'normal' and 'abnormal'. His work examines madness (Foucault 1965), illness, (1973), criminality (1977) and sexuality (1978) as concepts around which people have been labelled as insane, sick, criminal or perverted and describes the various oppressive practices that have proceeded from that labelling. Within a Foucauldian analysis, 'language is an instrument of power and people have power in society in direct proportion to their ability to participate in the various discourses that shape that society' (Freedman and Combs 1996:37–8). Following the work of Foucault, Michael White (e.g. White 1992) has discussed the idea that we tend to internalise the dominant narratives of our culture. Social constructionist and systemic therapies aim to deconstruct these narratives in ways that are in line with queer theory, in that we put the dominant narratives under the microscope for inspection and not those of 'the other'. For example, we would not ask 'Why are some people gay?' but 'How does heterosexuality become such a prized commodity?'. We therefore use deconstructive questioning to challenge and resist oppressive dominant discourses. Catherine illustrates this in her work with a single man below.

Sam, a 35-year-old black British gay man, requested therapy because he felt unable to have sexual encounters since being diagnosed with HIV one and a half years ago. Sam no longer felt able to flirt and if someone 'hit on' him in a club he would leave feeling annoyed with himself. He felt as if 'someone poured a bucket of cold water on me' and the smallest hint at sex reminded him that he was HIV positive. This had two effects: first he assumed he would be rejected because of his HIV status, and second he 'no longer felt good enough anymore'.

We started by deconstructing the idea that he was no longer good enough. Through questioning Sam about the qualities that he brings

to his friendships and relationships, Sam agreed that he would make a good boyfriend because he was loyal, honest, clear and interesting. He also discovered that he must have self-respect because he was turning down people who approached him in clubs because they just wanted 'his body', and he felt he had more to offer. What was interesting was that his friends refused to believe that he was not having sexual encounters with people but had for some reason stopped telling them about it. This alternative view of him held by his friends allowed us to deconstruct the idea that he would be rejected because of his HIV status. Midway through therapy, Sam reported that he had managed to stay in a club until closing and had flirted with others. CB questioned him about what it was about him as a person that would help her understand how he was managing to make these changes. Sam explained that he had had previous experience of adjusting to holding a minority status (how he was now seeing his HIV status). Sam spoke about his experiences of coming out to his family and of being black on the gay scene in London in the 1980s. He had recently bumped into someone he knew from a black gay support group he had attended in the 80s and was surprised to hear that he had been this man's role model because of his courage in telling his family.

Deconstructive questions and drawing on the views of other people in Sam's life allowed Sam to rediscover a story of himself as someone who had choices and courage and was experienced in disclosure and holding minority identities that he could feel ok about, even if met with disapproval from others. At the end of therapy he had started a new relationship, which he said felt like a 'training wheel'. Most importantly, Sam said he was 'not prepared to put myself in the bargain bin anymore'.

### *Political and ethical stance*

Social constructionist and systemic approaches to therapy do not claim to be politically neutral but actively concern themselves with ethics and the politics of power. Following Foucault, theorists like Michael White have proposed that therapy can bring about 'an insurrection of subjugated knowledges' (Foucault 1980:80–4) that allows people to lay claim to the many possibilities in their lives that lie beyond the dominant narratives.

Freedman and Combs (1996) discuss the ethics of postmodernism and therapeutic approaches. They contrast these with modernist ethics, which tend to be based in rules that can be prescribed and reinforced in a 'top down' manner. While we are all bound by our professional ethics and codes of conduct, systemic therapists are also interested in a different idea of

ethics, which takes account of power, social difference and context. Some critics have expressed concern that postmodern approaches are morally relativist and imply that one story or explanation is as good as another. However, as Freedman and Combs (1996) explain, ethics in this sense involve examining our beliefs and values, rather than taking them for granted and taking an explicit stance of making room for marginalised voices and cultures. These ideas have been essential for us as we both chose to work in sexual health services because of the diversity within the client group and the political and international nature of HIV.

## Queer(y)ing psychology training

One of our important roles is in contributing to the training of post-graduate psychologists. In 2006 the HIV and Sexual Health Faculty of the BPS conducted a survey of all 33 clinical psychology training courses in Britain (details of the survey can be found on the faculty web site: www.bps.org.uk/dcp-sexhealth/publications/publications_home.cfm). Of the 75 per cent of courses contacted that responded, 86 per cent taught trainees how to talk to their clients about sex in therapy. While 78 per cent of the courses that responded integrated sexual diversity into their teaching, only 56 per cent of courses explicitly covered working with lesbian and gay clients. Similarly, only 47 per cent discussed sexuality within a cultural context.

In the sessions we are invited to run, we try to introduce a social constructionist and queer perspective in a number of ways:

- We locate our perspectives by disclosing our own sexualities and the possibility of their fluidity and influences on this topic (e.g. work context, politics, ethnicity, age). Also stating that we are not taking an 'expert' position and inviting participants to contribute their views throughout.
- We present historical and cultural understandings of sexuality from a Foucauldian perspective.
- We present a continuum model of sexuality that emphasises fluidity and change (e.g. Klein, Sepekoff and Wolf 1990).
- We examine discourses supporting oppressive practices towards lesbians, gay men and bisexuals by looking at stereotypes and considering representations in popular media, for example the portrayal of lesbians, gay men or bisexuals as tragic, tormented or predatory figures in popular films.
- We abnormalise the 'normal' and expose the social and cultural practices that sustain a view of heterosexuality as 'natural' or 'normal' but present 'a-day-in-the-life-of' a heterosexual person in a world where the norm is to be homosexual (Butler 2004b).

- We put heterosexuality under the microscope by asking participants to consider how heterosexual privilege influences their lives e.g. by use of the 'heterosexual questionnaire' (Rochlin 1992), which asks heterosexuals questions that are usually asked of queer people (such as 'when did you first know you were straight) and heterosexual privilege (Bohan 1996), which lists unreflected upon privileges experienced by heterosexuals (such as having role models from childhood who show your affectional and sexual orientation is normal).
- We present case vignettes that consider how the 'norms' and social messages about sexuality might be conceived of differently and so impact on clients lives in various way, through the lens of old age, adolescence, ethnic minority, learning disability, and thus introduce the notion of levels of context and multiple identities.

Our aim is to encourage a questioning and deconstructive stance in workshop participants in order to ask clients about their individual contextual influences on their sexuality, rather than accepting heteronormative ideas from which to judge others who do not fit within this box.

## Conclusion

Queer theory provides an informative and creative complement to social constructionist and systemic ways of working with clients and in the training of therapists. It lends richness to deconstruction by emphasising heteronormative power and the oppressive practices that influence our clients' lives. We find such an approach essential in our work with clients, most of whom do not fit within dominant social groups, e.g. white and heterosexual. It is perhaps because of these differences that clients feel troubled and present for therapy. However, by validating the client's sexual and relationship choices by deconstructing norm-based messages and positioning the client as an expert on themselves, our clients find ways to resist oppressive narratives and continue to develop and practise their sexual and relational lives as they desire.

## References

Andersen, T. (1987) The reflecting team: dialogue and meta-dialogue in clinical work. *Family Process*, **26**, 415–28.

Anderson, H. and Goolishian, H. (1992) The client is the expert: a not-knowing approach to therapy. In S. McNamee and K. Gergen (eds), *Therapy as Social Construction*. London: Sage, pp. 24–39.

Bateson, G. (1972) *Steps to an Ecology of Mind*. New York: Ballentine.

Bohan, J.S. (1996) *Psychology and Sexual Orientation: Coming to Terms*. New York: Routledge.

Butler, C. (2004a) Lesbian and gay trainees: the challenges of personal and professional integration. *Lesbian and Gay Psychology Review*, **5**(1), 22–9.

Butler, C. (2004b) An awareness-raising tool addressing lesbian and gay lives. *Clinical Psychology*, **36**, 15–17.

Butler, J. (1990) *Gender Trouble: Feminism and the Subversion of Identity*. London: Routledge.

Cronen, V. and Pearce, W.B. (1980) *Communication, Action and Meaning: The Creation of Social Realities*. New York: Praeger.

Cronen, V.E. and Pearce, W.B. (1985) Toward an explanation of how the Milan method words: an invitation to a systemic epistemology and the evolution of family systems. In D. Campbell and R. Drapers (eds), *Applications of Systemic Family Therapy: The Milan Approach*. London: Grune and Gratton.

Denman, C. (2004) *Sexuality: A Biopsychosocial Approach*. Hampshire: Macmillan.

Foucault, M. (1965) *Madness and Civilisation*. New York: Pantheon.

Foucault, M. (1973) *Birth of the Clinic*. New York: Pantheon.

Foucault, M. (1977) *Discipline and Punish*. New York: Pantheon.

Foucault, M. (1978) *The History of Sexuality: An Introduction*, vol. 1. New York: Random House.

Foucault, M. (1980) *Power/Knowledge: Selected Interviews and Other Writings*. New York: Pantheon.

Freedman, J. and Combs, G. (1996) *The Social Construction of Preferred Realities*. New York: W.W. Norton.

Halperin, D.M. (1995) *Saint Foucault: Towards a Gay Hagiography*. Oxford: Oxford University Press.

Haraway, D.J. (1991) A cyborg manifesto. In D.J. Haraway (ed.), *Simians, Cyborgs and Women*. New York: Routledge, pp. 149–81.

Kitzinger, C. (1989) Liberal humanism as an ideology of control: the regulation of lesbian identities. In J. Shotter and K. Gergen (eds), *Texts of Identity*. London: Sage, pp. 82–98.

Kitzinger, C. (1990) Heterosexism in psychology. *The Psychologist*, **3**, 391–2.

Klein, F., Sepekoff, B. and Wolf, T.J. (1990) Sexual orientation: a multi-variable dynamic process. In T. Geller (ed.), *Bisexuality: A Reader and Sourcebook*. Albion, CA: Times Change Press, pp. 35–49.

Lax, W.D. (1992) Postmodern thinking in clinical practice. In S. McNamee and K. Gergen (eds), *Therapy as Social Construction*. London: Sage.

Madigan, S. and Epston, D. (1995) From Spychiartric gaze to communities of concern: from professional monologue to dialogue. In S. Friedman (ed.), *The Reflecting Team in Action*. New York: Guilford Press, pp. 257–76.

Maturana, H.R. (1978) Biology of language: the epistemology of reality. In G.A. Miller and E. Lennenberg (eds), *Psychology and Biology of Language and Thought*. New York: Academic Press, pp. 27–63.

Minton, H.L. (1997) Queer theory: historical roots and implications for psychology. *Theory and Psychology*, **7**, 337–53.

Pearce, W.B. (1994) *Interpersonal Communication: Making Social Worlds*. New York: Harper Collins.

Rochlin, M. (1992) Heterosexual questionnaire. In W. Blumenfeld (ed.), *Homphobia: How We All Pay the Price*. Boston: Beacon Press, pp. 203–4.

Sedgwick, E.K. (1990) *The Epistemology of the Closet*. Berkeley: University of California Press.

Simon, G. and Whitfield, G. (2000) Social constructionist and systemic therapy. In D. Davies and C. Neal (eds), *Pink Therapy 2: Therapeutic Perspectives on Working with Lesbian, Gay and Bisexual Clients*. Buckingham: Open University Press, pp. 144–62.

Spargo, T. (1999) *Postmodern Encounters: Foucault and Queer Theory*. Cambridge: Icon Books.

Taylor, G., Slots, B., Roberts, B. and Maddicks, R. (1998) A queer business: gay clinicians working with gay clients. *Clinical Psychology Forum*, **119**, 9–13.

White, M. (1992) Deconstruction and therapy. In D. Epston and M. White (eds), *Experience, Contradiction, Narrative and Imagination: Selected Papers of David Epston and Michael White 1989–1991*. Adelaide: Dulwich Centre Publication, pp. 109–51.

Wittgenstein, L. (1952) *Philosophical Investigations*. Oxford: Blackwell.